CLINICAL COURIER®

Vol. 21 No. 34 November 2003 ISSN 0264-6684

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Program Release Date: November 2003 Program Expiration Date: November 30, 2004

ACHIEVING REMISSION IN DEPRESSION: Managing Women and Men in the Primary Care Setting

A Case Study Approach

PRESENTED BY:

The Office on Women's Health
of the
US Department of Health and Human Services

IN COOPERATION WITH:

American Medical Association
Physicians dedicated to the health of America

American Psychiatric Association

American College of Physicians

American Academy of Physician Assistants

National Association of Managed Care Physicians

Society for Women's Health Research

This program is supported through an unrestricted educational grant provided by Wyeth.

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November 2003

Dear Colleague:

We are pleased to provide you with this continuing medical education newsletter, *Achieving Remission in Depression: Managing Women and Men in the Primary Care Setting—A Case Study Approach,* developed from the proceedings of a roundtable meeting presented by the Office on Women's Health of the US Department of Health and Human Services.

Depression is a greatly underdiagnosed and undertreated disorder that has significant economic and personal costs for patients and for our society at large. Unrecognized depression can result in morbidity and mortality; however, appropriate early diagnosis and treatment can significantly reduce these risks. Primary care physicians (PCPs) are often the first medical contact that patients suffering from depression encounter. Therefore, it is vital that PCPs are able to identify and treat the disease effectively. Achieving and maintaining remission in depression is the ultimate goal for PCPs and their patients and is specifically addressed in this educational program.

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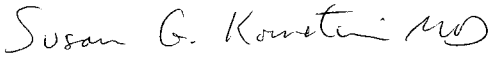
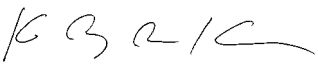
We thank you in advance for your participation and believe that you will find this newsletter to be an invaluable resource in the management of depression to achieve and maintain remission.

Best regards,





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ACHIEVING REMISSION IN DEPRESSION: Managing Women and Men in the Primary Care Setting

A Case Study Approach

Presented by The Office on Women's Health of the US Department of Health and Human Services

Overview

Of the multitude of diseases that today's primary care physician is called upon to treat, none is more common than depression.[1] This is not surprising, given estimates that 1 in 8 individuals in the United States may require treatment for depression in the course of a lifetime.[2]

Far more than a mere transient bleak mood, depression is a serious medical illness that can be intensely debilitating in virtually every realm of life. The patient with major depressive illness suffers physically, emotionally, socially, and financially. Research has demonstrated that depression can be as devastating as other chronic diseases, and often far more so. Of all chronic illnesses, only advanced coronary artery disease is associated with a greater rate of disability and loss of functional capacity than depression, and only arthritis causes more chronic pain.[3]

The evaluation and management of depression is often thought of as being within the sole purview of psychiatrists. However, the fact is that today, primary care physicians are providing a larger proportion of mental health services than are psychiatric specialists.[4] Several factors may be contributing to this trend, among them policies put in place by managed care and insurance providers. One of the most important contributors may be the fact that patients who are in pain, whether physical or psychological pain, are more likely to seek help from their primary care providers, whom they trust and with whom they feel comfortable, rather than from mental health providers. It appears that primary care physicians are stepping up to meet the challenge, given estimates that approximately half of antidepressant prescriptions are written by these professionals.

Nevertheless, the evidence is overwhelming that in all clinical settings, including both mental health and primary care settings, depression is substantially underrecognized and undertreated.[2,5] Only one third to one half of individuals who are suffering from a major depressive disorder are identified by clinicians.[2] Although this situation is of concern, it is easy to see why it exists. No matter how intense a patient's inner suffering, depression is often an outwardly "silent" disease. Patients seldom self-identify it and call it by name. Instead, they may present with a myriad of other complaints, somatic and otherwise, that can mislead even the most astute clinician. In many cases, it is only through proactive screening that the clinician will identify and accurately diagnose the patient with depression. When depression is accurately diagnosed and appropriately treated, it can almost always be treated successfully.[2]

Table 1

Treatment Outcomes in Depression[12,36]

• Response	Clinically significant reduction in baseline symptom severity
• Remission	Absence of symptoms; return of premorbid psychosocial functioning; no longer meets criteria for major depression
• Relapse	Return of depressive symptoms within 6 months following remission
• Recovery	Sustained period of remission of ≥6 months' duration following an episode of major depression
• Recurrence	New episode of depression following recovery from previous episode

EDUCATIONAL OBJECTIVES

Upon completion of this program, participants should be able to:

- Identify differences in the evaluation and treatment of depression by gender and by menopausal status
- Differentiate remission and response as goals of the treatment of depression
- Discuss strategies to achieve and maintain remission long term in patients with depression
- Discuss measures to evaluate remission and response to treatment
- Discuss differences among antidepressant classes with respect to safety and efficacy in women and men

TARGET AUDIENCE

Primary care physicians and healthcare professionals who care for patients with depression.

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Faculty Member	Grants/Research Support	Consultant/Scientific Advisor	Speakers Bureau	Other Financial or Material Support	No Financial Interest or Affiliation
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J. Lerner					X
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Importantly, the definition of successful treatment for depression has recently undergone a significant evolution. In the last 5 to 10 years, the treatment paradigm for depression has changed from one of satisfaction with symptom relief/response to one of reaching for long-term remission—that is, a virtually asymptomatic state (Table 1, page 1). When the treatments that are available today are applied with appropriate diligence, this goal is eminently achievable.

This newsletter presents three patients with various clinical presentations and describes the process of their diagnosis and management:

- Laura D., a 50-year-old woman who schedules an appointment with her primary care physician because she hasn't been feeling like herself
- Luis H., a 42-year-old accountant who offers a cluster of vague somatic complaints during an insurance physical—but fails at first to mention a worrisome family history
- Sarah R., an exhausted 24-year-old single mother of a 3 year old who finds herself pregnant again

Key clinical considerations for the diagnosis and management of depression accompany each case.

Method of Participation

The program consists of an 8-page *Clinical Courier®* with a CME Post-test.

This *Clinical Courier* should take approximately 2 hours to complete. The participant should, in order, review the educational objectives, read the newsletter, and return the completed Post-test and Evaluation Form to the address indicated to receive credit. The Evaluation Form provides each participant with the opportunity to comment on the extent to which educational objectives were met, the quality of the instructional process, the perception of enhanced professional effectiveness, the perception of commercial bias, and participant views on future educational needs. This credit is valid through November 30, 2004. No credit will be given after this date.

Evaluation

The Food and Drug Administration (FDA) has issued a concept paper that classifies commercial support of scientific and educational programs as promotional unless it can be affirmed that the program is "truly independent" and free of commercial influence. In addition to independence, the FDA requires that nonpromotional commercially supported education be objective, balanced, and scientifically rigorous. The policy further states that all potential conflicts of interest be fully disclosed to the program's participants.

Achieving Remission in Depression: Managing Women and Men in the Primary Care Setting—A Case Study Approach, as published in this issue of the *Clinical Courier*, reports highlights from a meeting of experts in treating depression held in Washington, DC, on March 17, 2003. This publication is intended for healthcare professionals who care for patients with depression. This newsletter was developed and produced by SynerMed Communications under an unrestricted educational grant from Wyeth.

The views presented herein are those of selected faculty and not necessarily those of the publisher, grantor, or the University of Minnesota Office of Continuing Medical Education, The Office on Women's Health of the US Department of Health and Human Services, or the following cooperating organizations: American Medical Association, American Psychiatric Association, American College of Physicians, American Academy of Physician Assistants, National Association of Managed Care Physicians, and Society for Women's Health Research. This material is prepared based upon a review of multiple sources of information, but it is not exhaustive of the subject matter. Therefore, healthcare professionals and other individuals should review and consider other publications and materials about the subject matter before relying solely upon the information contained within this *Clinical Courier*.

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Case 1: Laura D.

Presentation

Laura D. is a 50-year-old white, married mother of three who schedules an examination with you because she "just hasn't been feeling quite right." A part-time library assistant whose last child recently left for college, Laura likes staying busy; in addition to her work at the library, she does community volunteer work, plays tennis once a week, and tends her beloved garden. Lately, though, she says she doesn't have the energy for any of it. "I just feel wrung out," she tells you. "I can just about put in my hours at work. I was planning on adding more hours at the library now that Carol's gone, but now I don't know how I'd do it. I was thinking that maybe I'm anemic or something. I know what it's *not*, though. It's not about the kids leaving. By the time they left, believe me, I was *glad* to see them go. I'm fine with my empty nest. It's me I'm not fine with. All I know is that I'm just not myself anymore."

Evaluation and Diagnosis

It is readily apparent to you that this usually vivacious, animated patient is strangely subdued. A check of her chart reveals that her last menstrual period was 14 months ago. She confirms that she's had no further menses since then, so by definition she is in menopause. When asked, however, she denies vasomotor symptoms or other menopause-related discomforts.

When Laura's lab results return, you find a slightly elevated triglyceride level, but everything else, including her hemoglobin and hematocrit, is within normal limits. Considering several possibilities, you ask, "In the last month, have you lost pleasure in activities you normally enjoy?" At first she seems startled, but then she considers the question carefully before answering. "I hadn't thought of it that way," she finally replies. "I thought I was just too tired to do anything. But now that you mention it, it really *isn't* just that. I don't look forward to anything anymore. I just feel like, why bother?" She considers your second question, "In the last month, have you felt sad, down, depressed, or hopeless?" equally thoughtfully before admitting that, indeed, she has. As you suspect, further evaluation using the BATHE and SIG E CAPS interviewing questions indicates a diagnosis of depression.

Treatment Plan

After educating Laura about depression and the use of antidepressant medication in its treatment, you suggest initiating therapy with venlafaxine at a dose of 75 mg/d. You ask Laura whether she'd like to consider psychotherapy as well, but she declines for the time being.

Follow-up

You follow up by telephone after 2 weeks, at which point Laura says she's feeling "a little better." She denies any side effects and is willing to stay on the medication to see whether things improve. At her 4-week follow-up office visit, Laura continues to say that she feels "a little better, but I'm still not quite myself." "I wish I could enjoy things the way I used to," she goes on, "but maybe I'm just asking too much. After all, I definitely don't feel as bad as I did. Maybe that's enough. Maybe this is just the way things are around this time of life." You explain to Laura that the goal of treating depression is to abolish symptoms to the greatest extent possible, not just to minimize them, and you emphasize that she doesn't need to settle for anything less. You increase her venlafaxine dose to 150 mg/d. At follow-up 4 weeks later, Laura says that she is back to her old self. "I really feel 100% better," she says. "I really thought that that was as good as I was going to get. But you were right. I'm glad you didn't take my word for it!"

Key Clinical Considerations

- **The pervasiveness of depression demands routine screening.**

Many primary care physicians greatly underestimate the prevalence of depression in their practices. The fact is that patients with depression are abundant in primary care settings, where they are substantially more likely to present than in mental health specialty settings.[2] In fact, the available data suggest that up to *every other patient* sitting in your waiting room at any given time is suffering from a mental disorder.[4] Given the extremely high prevalence rate and the high likelihood of treatment success,[2] primary care physicians are well advised to screen their patients for depression as routinely as they would screen for other common chronic disorders, such as hypertension.

- **Rapid, reliable screening tools make diagnosing depression easily manageable in the space of an average office visit.**

Screening and diagnosis of depression do not require the use of long, complicated assessment scales. Easy, quick techniques with very high rates of reliability are available to facilitate recognition of depression. An affirmative answer to either or both of these simple screening questions—*In the last month, have you lost pleasure in the activities you normally enjoy?* and *In the last month, have you felt sad, down, depressed, or hopeless?*—is a positive screen for depression.

For an investment of only about 1 minute's time, the screening process can be taken a step further with the BATHE interviewing paradigm (Table 2), which utilizes a group of questions developed to build upon the commonly accepted problem-oriented medical record procedure and SOAP (subjective, objective, assessment, plan) record-keeping format.[6,7] Both of these tools can be used not only to identify depression but also to evaluate response to treatment on an ongoing basis. (It is worth noting that these evaluations are generally entirely reimbursable when coded properly, since exploration of the psychosocial aspects of patients' problems constitutes an elevated level of complexity in treatment delivery.[7]) The SIG E CAPS system (Table 3) is yet another easy-to-administer test that is useful for identifying which of the symptoms of depression a patient is experiencing.[6]

- **Menopause merits heightened vigilance for depressive symptoms, and for those who meet the criteria for major depression, antidepressant therapy should be first-line treatment.**

Data from the National Comorbidity Survey suggest that the menopausal transition period may be a time of increased vulnerability to depressive symptoms.[8,9] Some studies indicate that administration of exogenous estrogen may exert an antidepressant effect,[9] and preliminary evidence suggests that concomitant estrogen therapy increases both response and remission rates to selective serotonin reuptake inhibitors (SSRIs) in older women. In contrast, treatment with the serotonin-norepinephrine reuptake inhibitor (SNRI) venlafaxine appears to be equally effective with or without adjunctive estrogen.[10]

However, patients may currently be reluctant to take, and physicians may be reluctant to prescribe, hormone therapy, particularly in the absence of vasomotor symptoms. Thus, antidepressant therapy should be considered as first-line treatment for depressed women patients. Preliminary evidence suggests that while SNRI therapy may be more effective than SSRI treatment in bringing about remission in both younger and older women, the enhanced efficacy appears to be particularly substantial in postmenopausal women, for whom the noradrenergic effects of the SNRI may confer added benefit.[10]

Table 2

The BATHE Technique[7]

BATHE Element	Query/Statement	Purpose
• **B**ackground	"What is going on in your life?"	Elicits context of visit
• **A**ffect	"How are you feeling about that?"	Allows patient to report current feeling state
• **T**rouble	"What troubles you most?"	Elicits subjective meaning of the situation
• **H**andling	"How are you handling that?"	Provides an assessment of functioning
• **E**mpathy	"That must be very difficult for you."	Legitimizes patient's feelings and reactions

Table 3

SIG E CAPS System

S	Increased or decreased **sleep** and **sexual** desire
I	Decreased **interest** or pleasure in almost all activities
G	Inappropriate **guilt** or feelings of worthlessness/hopelessness
E	Decreased **energy** or fatigue
C	Decreased **concentration**
A	Increased or decreased **appetite** with weight gain or loss
P	**Psychomotor** agitation or retardation
S	**Suicidal** ideation, plan, or attempt

Adapted with permission from Lieberman JA III. Depression: a common illness uncommonly diagnosed. *Psychiatric Ann*. 2002;32:522-526.[6]

- **Remission, not response, is the target of treatment.**

Just about a decade ago, any degree of relief of depressive symptoms was considered a sufficient outcome of therapy for depression. It is now evident, however, that such partial responses are associated with greater functional impairment and a greater risk of relapse and suicide.[11] Moreover, it is now clear that neither clinicians nor their patients need to be satisfied with such a subpar goal. The expected treatment outcome for depression is now one of full remission—that is, improvement of sufficient magnitude that the patient is completely, or nearly completely, asymptomatic for an extended period.[12] This change in paradigm demands that clinicians shift their approach to the treatment of depression to be more consistent with their approach to other chronic medical illnesses. Just as a treated blood pressure of 160/100 mm Hg would not be considered an acceptable treatment outcome in a hypertensive patient, incomplete relief of symptoms should not be considered "good enough" in a patient with depression.

- **During medication trials, don't quit too quickly.**

Recent research has called into question the traditionally accepted adequate duration of treatment, which called for initiating a change in medication in

the absence of marked improvement within 4 to 6 weeks.[13,14] In one study, treatment persistence with the original agent prescribed resulted in an increase in the remission rate from 32% at the 6-week point to 52% at the 12-week mark.[13] In another, patients who had achieved only a satisfactory therapeutic response at 12 weeks went on to full remission after 16 more weeks.[14] Thus, when remission is not quickly forthcoming, maximizing the dosage of the current medication and monitoring patients for potential drug-related adverse events may be effective in bringing about remission over time.

Case 2: Luis H.

Presentation

Today, you're seeing Luis H., a 42-year-old Hispanic accountant and father of two, who has scheduled an appointment with your office for a routine insurance physical. Although he appears to be in good overall health, he has answered affirmatively to a number of questions on the insurance form relating to somatic symptoms and minor health-related problems. When you question him about his answers, he describes vague, unfocused complaints, including sleeplessness and fatigue.

Evaluation and Diagnosis

At first reserved, he gradually becomes more forthcoming in response to your questions. He admits that he "has a lot of worries" and hasn't had a good night's sleep in "about a year." "I wake up every morning at about 3 AM and just can't get back to sleep," he says. "I toss and I turn and I worry… about the kids, about my job. I'm so tired every day that I'm on the kids' cases every morning before I leave. And once I get to work, I can't focus, and I can't seem to get anything done. And I've been making all kinds of mistakes lately, and my boss has noticed. If I don't shape up soon, I'm not going to have a job to worry about. I'm not sure how much longer I can go on like this."

Further questioning reveals that Luis meets the diagnostic criteria for major depression. His statement about not knowing how much longer he can go on prompts you to ask him whether he has considered harming himself in any way. Reluctantly, he admits that he has considered the option from time to time. "Sometimes it seems like the only way out," he says. He further discloses that his mother died by suicide 20 years ago, shortly after her own mother's suicide. "It destroyed our family," he says. "I'd never been able to forgive either one of them. But now I understand." Concerned about the level of risk given Luis's responses to your questions and his family history, you elect to refer him to a psychiatrist for management.

Treatment Plan

In full agreement with your assessment that Luis appears to be at high risk, the psychiatrist agrees to see him that afternoon and to continue to comanage him until he has been stabilized. A trial of controlled-release paroxetine, initiated at 25 mg/d and titrated at weekly intervals to 37.5 mg/d and then to 50 mg/d, relieves some, but not all, of Luis's symptoms. The psychiatrist substitutes bupropion (initiated at 150 mg/d, titrated to 150 mg BID, and finally adjusted to the maximum dose of 200 mg BID) and continues biweekly visits to carefully track his progress.

Follow-up

After 6 months of bupropion treatment and supportive visits, and convinced that Luis has returned to his premorbid level of functioning and is no longer a suicide risk, the psychiatrist refers the patient back to you for primary long-term management. You and Luis agree that you will see him once a month for follow-up and medication renewals, and he promises to let you know immediately if he notices any exacerbation of depressive symptoms.

Key Clinical Considerations

• Depression is the most disabling of all diseases.

According to the World Health Organization, depression is the leading cause of disability in the United States and worldwide.[15] According to a study recently published in the *Journal of the American Medical Association*, workers with depression lose nearly four times more productive time at work than their nondepressed colleagues.[16] The study also demonstrated that antidepressant use among workers with depression was low (<30%), and mean self-reported treatment effectiveness was only moderate,[16] suggesting not only that opportunities to treat depression are being missed but also that when depression is treated, it is often treated insufficiently (that is, short of remission).

• Somatization is a signal to screen for depression.

Many patients are unable to articulate their feelings or are unable to self-identify depression. Such patients are far more likely to verbalize nonspecific physical symptoms. Thus, vague somatic complaints should prompt the clinician to screen for depression, particularly in men, who are more likely to report symptoms like fatigue, sleep disturbances, and irritability than symptoms like sadness or worthlessness.[17] Notably, Hispanic patients of both genders are more likely to express somatic symptoms and nonspecific complaints than psychological distress.[18] For example, Hispanic patients may be more likely to say, "I don't feel well" or "I am nervous" than to say "I'm depressed."[18,19]

A recent study of 98 Hispanic and non-Hispanic white patients showed that once treatment is initiated, Hispanic patients are less likely than white patients to complain about their medication (22% vs 37%, respectively). The most common complaints voiced by patients in both groups were that the medication was not working (more common in Hispanic patients, 13% vs 9%, respectively) and that the medication was producing adverse effects (more common in white patients, 21% vs 9%, respectively).[20]

• Suicide is a particularly serious risk in men.

Suicide is the ultimate negative outcome in depression, and it occurs with distressing frequency in patients who fail to receive appropriate treatment. Estimates are that 10% to 15% of untreated patients with bipolar I disorder commit suicide—a rate that is 15 to 20 times higher than the suicide rate in the general population.[2] While women are more likely than men to attempt suicide, four times as many men as women succeed in their attempts.[17] This differential is due in part to the fact that men use more lethal methods to attempt suicide, but the National Institute of Mental Health notes that it also is related to the fact that men are less likely to seek treatment for depression—treatment that is often lifesaving.[17]

• Primary care physicians retain the right to refer at will.

It is widely agreed that the long-term treatment of depression is well within the purview of the primary care physician.[2] Nevertheless, the primary care physician may elect to refer a patient to a mental health specialist for treatment for any of a variety of reasons, including elevated suicide risk, existence of a complicating comorbid disorder (such as substance abuse or anxiety disorder), need for adjunctive psychotherapy, or failure to achieve expected progress in treatment. Most importantly, the primary care physician can elect to refer whenever his or her comfort level suggests it.

• Identifying an optimal treatment typically takes trial and error.

Six major classes of antidepressants, each regulating slightly different neurotransmitter systems, are currently available. All are effective—but not every drug is effective for every patient. While the initial antidepressant tried

generally produces a response rate in just 50% to 60% of patients (and remission rates are lower),[21] the fact remains that depression can almost always be treated successfully in almost every patient in whom it is identified.[2] Thus, it should be accepted that more than one medication trial (and sometimes several) may be necessary before an optimal regimen is identified—just as is the case in the treatment of hypertension or diabetes. Although the choice of an initial agent is based to some extent on trial and error, consideration of the characteristics of the various antidepressant classes can help to guide selection (Table 4). As the data listed in Table 4 suggest, and as additional studies indicate, agents that affect more than one neurotransmitter system (eg, the tricyclics, the monoamine oxidase inhibitors [MAOIs], and the SNRI venlafaxine) are often associated with higher rates of remission than are antidepressants that affect only one neurotransmitter (eg, the SSRIs).[21-24]

Case 3: Sarah R.

Presentation

Sarah R., a 24-year-old single white mother of a 3 year old, arrives in your office with the complaint that she is "completely exhausted all the time" and wants to do "nothing but sleep." "I've missed work twice this week because I just couldn't get out of bed," she reports. "Everything is such a huge effort. When I walk to the car, I feel like I've run a marathon." Sarah is 2 months pregnant with her second child, and though she appears warn and haggard, her complaints of anergia seem too severe to be accounted for by her pregnancy alone. You decide to investigate further.

Evaluation and Diagnosis

Your physical examination reveals that except for a weight loss of about 5 lb, Sarah is in good overall health, with no apparent pregnancy-related

Table 4

Comparison of Major Antidepressant Classes[36-47]

Antidepressant Class	Mechanism of Action	Response and Remission Rates*	Other Characteristics
MAOIs, older (phenelzine, tranylcypromine)	Irreversible inhibition of MAO-A and MAO-B; enhance NE, 5-HT, DA	60%-70%	May be better in atypical depression Require dietary restrictions
TCAs (amitriptyline, amoxapine, desipramine, doxepin, imipramine, nortriptyline, protriptyline, trimipramine)	Block reuptake of NE, 5-HT	43%-70%† 25%-60%†	Analgesic, anticholinergic, and antimuscarinic actions High side-effect burden
Tetracyclic (maprotiline)	Block reuptake of NE	53%-63%	Similar to TCAs Risk of seizures at higher doses
SSRIs (fluoxetine, sertraline, paroxetine, citalopram, escitalopram, fluvoxamine)	Selectively block reuptake of 5-HT	60%-70% 20%-35%	Broad comorbidity coverage Less side-effect burden vs TCAs Safe in overdose
SNRI (venlafaxine)	Block reuptake of 5-HT and NE	65%-76% 37%-45%	Higher remission rates Less side-effect burden vs TCAs Safe in overdose
NDRI (bupropion)	Block reuptake of NE and DA (?)	52%-70%	Effective for smoking cessation Less sexual dysfunction Safe in overdose
SA (mirtazapine)	Potent antagonist of 5-HT_2, 5-HT_3, and H_1 receptors; moderate α_1-adrenergic antagonist; moderate antagonist at muscarinic receptors	70%	Safe in overdose Common TCA and SSRI side effects minimized Sedation, weight gain
SA/SRI (nefazodone)	Antagonist of 5-HT_2 receptors and blocks reuptake of 5-HT and NE	35%-67% 35%-52%	Modest antidepressant Used mainly for hypnotic and anxiolytic effects

* Commonly accepted definitions: response = ≥50% reduction in the Hamilton Rating Scale for Depression (HAM-D) or Montgomery-Asberg Depression Rating Scale (MADRS) score; remission = absolute score of ≤7 on the HAM-D-17 or absolute score of ≤10 on the HAM-D-21 scales.

† Variability in response and remission rates due to heterogeneous selectivity on norepinephrine and serotonin within the class; higher rates associated with agents that have an approximately equal effect on both neurotransmitters. DA = dopamine; 5-HT = serotonin; MAOIs = monoamine oxidase inhibitors; NDRI = norepinephrine–dopamine reuptake inhibitor; NE = norepinephrine; SA = serotonin antagonist; SA/SRI = serotonin antagonist/serotonin reuptake inhibitor; SNRI = serotonin–norepinephrine (noradrenergic) reuptake inhibitor; SSRIs = selective serotonin reuptake inhibitors; TCAs = tricyclic antidepressants.

or general medical problems; her lab results confirm your clinical impression. You note, however, that Sarah suffered an episode of postpartum depression (PPD) following the birth of her first child. You decide to look further by using the BATHE questions. When you ask Sarah what is going on her life, she says, "Nothing. Nothing at all. I go to work, and I come home—to my parents' house. That's where my daughter and I are stuck living. My parents and I are always at each other's throats. But I'm a teacher's aide. Where am I going to go on my salary?"

When you ask Sarah how she feels about this situation, she conveys her sense of hopelessness in her reply. "Honestly, I hate it," she says. "But I'm stuck. I can't see any way out. I try and I try, but I can't manage to save a cent. Every paycheck is spent before I even get it. How am I ever going to be able to afford rent anywhere else?" When you ask Sarah what troubles her most, she says that it's the feeling of being constantly scrutinized by her parents, who make it clear that she's been quite a disappointment to them. "My mother makes me a nervous wreck because she second-guesses everything I do, and my father is constantly telling me how to run my life." When you ask how she's handling the situation, she says, "Not very well. I have no appetite. I'm having a hard time sleeping—I can't fall asleep, and when I finally do, I wake up way before the alarm rings—and I'm always jittery and so *mad*. I yell at my daughter, I yell at the kids at school, and then I cry at the drop of a hat."

Treatment Plan

After agreeing with Sarah that it must be very difficult to function well under the current circumstances, you explain that she appears to be suffering from symptoms of depression. In view of the fact that Sarah is still in her first trimester of pregnancy and that her depression is not severe, you decide to refer her for psychotherapy. With Sarah's permission, you maintain contact with her therapist, who, after several weeks, concedes that they are making progress, but "not enough." "I'm worried about her," she admits.

Follow-up

When Sarah comes in a month later, she is severely depressed. "She's a good therapist," Sarah says. "It's not her fault. We talk about my situation; she tries to help me 'problem solve.' I'm trying, she's trying, but it's like there's some *thing* inside that won't allow me to see that there could be any light at the end of this tunnel." Sarah has lost 3 more pounds and admits that she has a great deal of difficulty eating. After making a risk/benefit assessment, in which you consider Sarah's history of PPD and the danger posed to the fetus by her inability to eat and care for herself properly, you decide to prescribe fluoxetine and advise Sarah to continue in psychotherapy.

On follow-up 4 weeks later, Sarah has improved significantly. "My situation still stinks," she says, "but it doesn't have to be forever. After the baby's born, I'm going to start taking classes at the community college. I'm going to study to be an X-ray technician; they make decent money. I told my mother that if she ever wants me out of her house, she's going to have to watch my daughter and the baby a couple of nights a week. She didn't exactly jump for joy, but she'll do it. And then I'll finally be the one to be responsible for myself and my kids."

Key Clinical Points

- **When it comes to depression, pregnancy is no protection.**

The postpartum period is well acknowledged to be a period of increased risk for depression, while pregnancy had been believed to be a time of relative protection against the condition. However, there is growing consensus that pregnancy does not protect against mood disorders.[25,26] In fact, in at least one study, self-reported depression symptom scores were higher during pregnancy than postnatally.[26] Thus, clinicians need to be prepared with treatment strategies for women who become pregnant and either develop de novo depression or have been on maintenance therapy for the disorder.

- **A history of depression should raise the index of suspicion for PPD.**

Depression prior to or during pregnancy has been found to be the strongest predictor of PPD.[27,28] Depression prior to or during pregnancy and the postpartum period has been shown to have severe deleterious effects not only on the mother but on the fetus and neonate as well.[29-32] Notably, these effects may well be enduring. Children over the age of 1 year whose mothers suffered from PPD have been reported to be more prone to cognitive deficits and behavioral problems than children whose mothers were not depressed.[31] Thus, clinicians are well advised to carefully evaluate pregnant and postpartum women with any history of depression and to consider initiating treatment.

- **Depression during pregnancy demands careful consideration of the risks associated with treatment—and nontreatment.**

Medical mandate is to avoid exposure to medication during pregnancy to the extent possible. In all cases, however, the decision must be made by carefully weighing the risks and benefits as they impact both the mother and the fetus. While reluctance to treat depression immediately and aggressively may be understandable in certain circumstances (pregnancy being one), it must be understood that there also is risk associated with failure to treat on a timely basis. Untreated depression can impair a woman's ability to care for herself during pregnancy, interfering with nutrition, sleep, and the ability to follow medical directions.[33] The available data indicate that untreated depression during pregnancy adversely impacts obstetric outcome.[29] Moreover, early and aggressive treatment of depression is key to avoiding chronicity. Research demonstrates that the longer depression endures, the more difficult it is to ameliorate. Patients with depression of more than 52 weeks' duration have been shown to be substantially less likely to achieve remission.[34]

- **Used solo, psychotherapy may not be sufficient.**

While psychotherapy alone may be a satisfactory treatment start, it must be acknowledged that, when used alone, it may not be enough to bring about remission. Although research indicates that mild to moderate depression may be treatable with psychotherapy alone, severe depression is more likely to respond to psychotherapy in combination with antidepressant medication.[35] Psychotherapy is particularly useful for improving psychosocial function and for encouraging adherence to pharmacotherapy over the long term in order to sustain remission.

Summary and Conclusions

Primary care physicians are playing an increasingly vital role in the recognition and treatment of depression, a disease that historically has been underdiagnosed and undertreated in every clinical setting. Quick, reliable screening tools are available to make depression easy to identify in the course of an average office visit. In primary care settings, patients with depression present at least as often as patients with other chronic medical conditions like hypertension and metabolic disorders, and timely diagnosis and treatment can be equally lifesaving.

The past decade or so has brought several new medications for the treatment of depression—and with them, a major change in what is viewed as an acceptable outcome. Where once we viewed response and relief of symptoms as all that could realistically be hoped for, it is now clear that more is possible. Remission, defined as virtual absence of depressive symptoms and return to premorbid level of psychosocial functioning, is now the ultimate therapeutic goal. With today's treatments, it is an exceedingly achievable one.

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ACHIEVING REMISSION IN DEPRESSION: Managing Women and Men in the Primary Care Setting

A Case Study Approach

Post-test

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Release Date: November 2003
Expiration Date: November 30, 2004

1. Most patients with depression are managed:
   a. By psychiatrists
   b. By psychologists
   c. By primary care physicians
   d. In psychiatric hospitals
2. According to available research, depression may affect approximately what proportion of your patients?
   a. Up to 10%
   b. Up to 15%
   c. Up to 25%
   d. Up to 50%
3. Which of the following is *not* one of the available easy-to-administer screening tools for depression?
   a. CALL-D
   b. SIG E CAPS
   c. BATHE
4. Which of the following antidepressants affect(s) more than one neurotransmitter system?
   a. A TCA
   b. An SSRI
   c. An SNRI
   d. a and c
   e. a and b
5. Today, the ultimate goal of treatment of depression is:
   a. To achieve response to treatment
   b. To achieve full remission
6. Compared with women, which symptom of depression are men less likely to report?
   a. Fatigue
   b. Sleep disturbances
   c. Irritability
   d. Sadness
7. Which of the following statements is true about suicide in men versus women?
   a. Women are four times more likely than men to succeed in suicide attempts.
   b. Men are four times more likely than women to succeed in suicide attempts.
   c. Men are two times more likely than women to succeed in suicide attempts.
   d. Women are two times more likely than men to succeed in suicide attempts.
8. Antidepressants that focus on one neurotransmitter are more likely to be effective than those that affect more than one neurotransmitter.
   a. True
   b. False
9. The strongest predictor of postpartum depression is:
   a. Depression during adolescence
   b. Premenstrual dysphoric disorder
   c. Depression prior to or during pregnancy
   d. Need for delivery by caesarean section
10. Which of the following statements is true?
    a. Depression is the most disabling of all illnesses.
    b. Workers with depression lose nearly four times more productive time at work than their nondepressed colleagues.
    c. Depression often is treated insufficiently (short of remission).
    d. All of the above.

Please circle the correct answer to the post-test questions.

1. A B C D	3. A B C	5. A B	7. A B C D	9. A B C D
2. A B C D	4. A B C D E	6. A B C D	8. A B	10. A B C D

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Vol. 21 No. 34

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